Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement of $71.00 for date of service 05/09/01.

   b. The request was received on 02/13/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 02/12/02
   b. HCFA(s)-1500
   c. TWCC 62 forms
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Based on Commission Rule 133.307 (g) (4), the Division notified the insurance carrier Austin Representative of their copy of the request on 05/03/02. The Respondent did not submit a response to the request. The "No Response Submitted" sheet is reflected in Exhibit II of the Commission's case file.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 02/12/02:
   "The last denial received on this claim states, 'Pre-authorization not obtained'. Per Rule 134.6000, [sic] a follow-up office visit for monitoring medications on a patient does not meet the pre-authorization requirements….I submit this is a legitimate service and deserves full reimbursement from the carrier for $71.00."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 05/09/01.

2. The provider billed a total of $162.00 for the date of service in dispute.

3. The carrier did not reimburse the provider for the disputed date of service. The EOB(s) have the denials of:

"A,230 TREATMENT NO AUTHORIZED *Pre-authorization Not Obtained";
"F,246 F – REDUCED ACCORDING TO FEE GUIDELINE".

4. The amount in dispute per the TWCC-60 is $71.00.

5. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
05/09/01	99214	$162.00	$0.00	A,F	$71.00	Rule 134.600; MFG CPT descriptor	Per Rule 134.600, CPT code 99214 does not require pre-authorization. Reimbursement in the amount of **$71.00** is recommended.
Totals		$162.00	$0.00				The Requestor **is** entitled to reimbursement in the amount of **$71.00.**

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $71.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 23rd day of July 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.